EYESITE

If you have any questions or concerns, do not hesitate to ask for assistance. We are happy to help.

Patient Information: Name: _____ Last, First Date of Birth: ___/___/_____ Sex: _____ Address: _____ _____ Home Phone: _____ Cell Phone: _____ E-mail: _____	Last PCP Visit: ___/____/____ PCP Doctor: _____ Last Eye Exam: ___/___/____ Previous Eye Doctor: _____ Employer: _____ Work Phone: _____ Occupation: _____
Parent, Spouse, or Responsible Party (if different from patient): Name: _____	

Insurance Coverage – Primary: Insurance Name: _____ Policy Number: _____ Policy Holder: _____ Policy Holder DOB: _____ Employer: _____ Policy Holder's Relationship to Patient: _____	**Insurance Coverage – Secondary:** Insurance Name: _____ Policy Number: _____ Policy Holder: _____ Policy Holder DOB: _____ Employer: _____ Policy Holder's Relationship to Patient: _____

Medical History

Do you have any allergies to medication? Yes / No
If Yes, please list medication(s)/reaction: _____
_____

Please list current medications and what the medication is for:

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Medication: _____ Reason: _____

Do you wear Glasses? Yes / No

Do you wear contact lenses? Yes / No . Are you interested in being fit for contact lenses? Yes / No

PLEASE FLIP OVER

Please check all that apply:

Patient medical history and family history:			**Do you currently have any of the following symptoms? If yes, please describe below.**	
Self		**Family/Who**		
□	Allergies	□ _____	□	Blurry Distance Vision
□	Anxiety	□_____	□	Blurry Intermediate/Near Vision
□	Arthritis	□_____	□	Burning Eyes
□	Asthma	□_____	□	Double Vision
□	Auto-Immune Disorder	□_____	□	Dry Eyes
□	Cancer	□_____	□	Eye Pain
□	Cardiovascular	□_____	□	Eye Strain
□	Depression	□_____	□	Flashes of Light in Vision
□	Eczema	□_____	□	Floaters in Vision
□	GI Issues	□_____	□	Itchy Eyes
□	Headaches/Migraines	□_____	□	Light sensitivity
□	Hepatitis	□_____	□	Mucous Discharge
□	Heart Disease	□_____	□	Poor Night Vision
□	High Blood Pressure	□_____	□	Red Eyes
□	High Cholesterol	□_____	□	Watery Eyes
□	HIV	□_____		
□	Muscular or Bone Issues	□_____		DESCRIBE ABOVE:
□	Pregnant or Nursing	□_____		_____
□	Rosacea	□_____		_____
□	Thyroid Condition	□_____		_____
□	Type 1 Diabetes	□_____		_____
□	Type 2 Diabetes	□_____		
□	Amblyopia	□_____		Current or History of Eye Injury
□	Cataracts	□_____		Current or History of Eye Patching
□	Glaucoma	□_____		
□	Macular Degeneration	□_____		History of Eye Surgery,
□	Retinal Detachment/Disease	□_____		If yes, please explain: _____
□	Strabismus (Lazy Eye)	□_____		_____
				_____
Additional Eye or Medical Condition/Concerns: _____ _____				

Social History (If you prefer, you may discuss this portion with your doctor and leave blank)

Do you drive? Yes / No / Daytime Only

Tobacco Use: Yes / No / Prior If Yes, _____ Packs per Day for ____ Years. When did you quit? _____

Alcohol Use: None / Social Use Only / 1-2 Drinks Daily / Above Average / Chemical Dependence / Prior Use

Drug/Narcotic Use: None / Recreational Use / Chemical Dependence / Prior Use

Is there any additional information or concerns you have for the doctor? If yes, please explain:

_____
_____
_____
_____